Health Care Coordination

Guideline: Health Care Coordination should be provided for each person to ensure that health care needs are identified; and that services, treatment, and follow-up are procured and provided in an efficient, timely, and effective manner.

DEFINITIONS:

Health Care Coordinator: A registered nurse who is responsible to ensure that the health care program of each person is properly formulated, implemented, and documented so that the health care needs are met.

Coordination: The process of motivating and leading other members of the health care team to carry out desired and expected actions.

Health Care Team: The group of team members from the interdisciplinary team whose primary focus is health related. This may include but not be limited to registered nurses, physicians, nurse practitioners, licensed practical nurses, dentists, pharmacists, occupational therapists, physical therapists, dietitians, the person receiving services, and family members.

Primary care prescribers: Physicians, nurse practitioners, and physician's assistants who provide primary care services and are authorized to prescribe medications and treatments for people on their assigned caseloads.

BASIC ASSUMPTION:

The Health Care Coordinator should utilize the other members of the health care team as resources in providing health care coordination. Many of the tasks in this guideline may be delegated to and implemented by licensed practical nurses.[1] However; some tasks may not be delegated to the LPN:

1. "The analysis and synthesis of clinical information and the formulation of problem statements and/or nursing diagnosis requires the knowledge base and skills that are within the scope of practice of registered nurses and may not be delegated to the LPN." [2]
2. "The LPN may collect health care data related to vascular, diabetic and/or pressure ulcer(s) in order to assist with classification or staging. However, the analysis and synthesis of clinical information and the formulation of problem statements, nursing diagnosis and treatment plans requires the knowledge base and skills that are within the scope of practice of the registered nurse and may not be delegated to the LPN. It is recommended that agencies develop and implement policies and guidelines requiring assessment and frequent reassessment by the RN."[3]

RATIONALE:

1. People with developmental disabilities deserve the same scope and quality of health care available to the general population.
2. Many people with developmental disabilities require assistance and training in identifying health needs, determining sources of services, and obtaining health services because of limited abilities to independently access quality health care.
3. Prompt, accurate, and effective communication among nurses, primary care prescribers**,** and other interdisciplinary team members is essential to the delivery of quality health care.

Rationale cont'd

4. Thorough, comprehensive documentation of health status and procedures is necessary and serves as:
   a. a communication tool among professionals,
   b. a means to establish baseline information,
   c. a method to provide information for analysis and diagnosis,
   d. data for retrospective history review.
5. An organized system of planning, implementation, evaluation, and record keeping is necessary to ensure that health treatments and services are scheduled, performed, and documented without omission or unnecessary duplication.
6. Health education programs are essential to promote each person's self-care skills as well as to provide the knowledge necessary for staff to deliver optimal health care.

Agency Responsibility

1. A formal system of communication should be in place to ensure that information is relayed from shift to shift in a consistent, thorough, and accurate manner. The system should incorporate a means of communication to and from licensed and non-licensed personnel.
2. When staff training needs are identified, training programs should be developed and/or procured to ensure staff has sufficient knowledge to meet the overall health needs of the person receiving services.
3. Each person should have a registered nurse as his or her Health Care Coordinator to implement the expected outcomes outlined below.
4. Administrative support should be provided when the Health Care Coordinator identifies the need for assistance in ensuring that the health care needs are identified; and that services and treatments are procured and provided in an efficient, timely, and effective manner.

EXPECTED OUTCOMES:

Assessment

The specific health strengths and needs as well as the status on the health continuum should be identified for each person.

1. The Health Care Coordinator is responsible for ensuring that nursing assessments are performed based on the needs of each person and as required by regulations. These assessments are documented in the individual's record.
2. Health promotion strategies should be designed to reach or maintain the optimal level of health for each person. These strategies should be documented in each person's Single Plan.
3. The Health Care Coordinator, along with other members of the interdisciplinary team, is responsible for assessing and identifying health care training needs for each person. Individualized training needs should be included in each person's Single Plan.
4. Staff training needs should be identified by the Health Care Coordinator and other members of the interdisciplinary team. The Health Care Coordinator may be responsible for confirming that health-related training has been procured as needed.

Diagnostic Reasoning

The Health Care Coordinator should be knowledgeable of the health status of each person on his or her caseload.

1. Systems should be in place whereby the Health Care Coordinator is kept informed and knowledgeable of current changes or abnormalities in laboratory studies, x-ray reports, weight status, and other health risk indicators.
2. Change of health status should be reported as appropriate to the primary health prescriber and documented in the nurses' notes.

Implementation

The health care program delivered to each person should be coordinated so that comprehensive, high quality care is provided without omission or unnecessary duplication.

1. Health education programs should be implemented so that each person reaches and maintains the highest level of independence possible in caring for personal health care needs. Program implementation should be coordinated through the interdisciplinary team. Progress should be documented in the individual's record.
2. Provisions should be made for acute care, treatment, and restorative therapy once a diagnosis of illness is made. The person's response to treatment should be documented in nursing and medical progress notes.
3. Adaptive equipment needed by people with existing disease or disability should be identified, procured, and utilized in a timely manner. The effects of these measures should be monitored on a regular basis and documented in the individual's record.
4. The Health Care Coordinator should be responsible to ensure that all health care appointments are scheduled, met, and documented. Pertinent appointment information should be communicated to the necessary personnel and documented according to the policy/procedure in each facility.
5. Systems should be in place to ensure that all primary care prescriber's orders (e.g., laboratory tests, diagnostic procedures, treatments, medications) have been implemented and documented in the individual's record.
6. Systems should be in place to ensure that written and verbal communication is provided to the primary care prescriber and the QMRP/Service Coordinator regarding the findings and recommendations made by medical consultants.
7. Upon approval of the primary care prescriber, the Health Care Coordinator should be responsible for ensuring that timely implementation and documentation of recommendations from consultants occurs.

Evaluation

The health care program should be evaluated by the Health Care Coordinator.

1. The Health Care Coordinator should ensure that systems are in place so that:
    a. the health plan in the Single Plan is implemented;
    b. reports of tests, diagnostic procedures, and referrals are reviewed by the primary care prescriber;
    c. documentation is complete and readily accessible in the individual's record;
    d. follow-up treatment or action is implemented as ordered or recommended.

2. The Health Care Coordinator should notify appropriate persons if the health care program has not been adequately carried out and documented.

REFERENCES

1. South Carolina Board of Nursing (2004). Laws Governing Nursing in South Carolina; Article 1 § 40-33-20. Definitions.

2. South Carolina Board of Nursing (April, 2003). Advisory Opinion – Question 23. Available: http://www.llr.state.sc.us/POL/nursing/index.asp?file=advisoryop23.htm *(Response to question: Is it within the role and scope of responsibilities of the licensed practical nurse (LPN) to perform physical assessment?)*

3. South Carolina Board of Nursing (September, 2003). Advisory Opinion – Question 49. Available: http://www.llr.state.sc.us/POL/nursing/index.asp?file=advisoryop49.htm *(Response to question: Is it within the role and scope of responsibilities of the licensed practical nurse (LPN) to evaluate and/or stage vascular, diabetic or pressure ulcers?)*